GEORGIA BOARD OF NURSING

237 Coliseum Drive
Macon, Georgia 31217

VERIFICATION OF EMPLOYMENT BY APPLICANTS FOR LICENSURE BY EXAMINATION FOR INTERNATIONAL APPLICANTS

Instructions:

1. Applicant: Complete Section I and sign.
2. Submit this form to your employer to verify the numbers of hours worked. List all employment (Personnel Director, Human Resources Department) that can provide verification. Ask the employer to complete this form and place it in a sealed envelope for you to submit with your application.

Section I (To be completed by applicant)

*The name and address of your employer on this form must match the name and address you listed under "Employment History" on the application.

Printed Name of Applicant: _____
Last **First** **Middle** **Maiden**

Applicant's Address: _____
Street **City** **State** **Zip Code**

RELEASE: I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Nursing. I understand this information is required as part of the application for licensure process.

Signature of Applicant _____ **Applicant Phone Number (s)**_____

APPLICANT – DO NOT WRITE BELOW THIS LINE:

Section II (To be completed by person verifying employment):

Instructions:

1. Complete Section II of this form.
2. **You must respond to all questions or this form will not be accepted by the Board office**.
3. Employment must have been for compensation.
4. Each title held with one employer requires a separate verification form completed.
5. Return the form to the applicant in a sealed envelope.

1. Name of Facility/Business/Employer: _____ Phone Number: ( ) _____
   Is this a federal agency of the United States Government? ❒ **No** **Yes** ❒
   Is this an acute care inpatient hospital? ❒ **No** **Yes** ❒

2. Physical Address of Location: _____
   City **State** **Zip**

3. Employee's Position/Title: _____

4. Is an RN license necessary for employment in this position? ❒ **No** **Yes** ❒

5. Is APRN authorization required for employment? ❒ **No** **Yes** ❒

6. Is a certification for a military medical corpsman or paramedic necessary for employment in this position? ❒ **No** **Yes** ❒

7. Identify the actual physical location where the employee practiced to include facility name, city/state if different than # 2 above or indicate same as above:
   _____

8. Employment Dates: From: _____ **(mo/yr)** - To: _____ **(mo/yr)**
   Were there any periods of extended absence during employment? ❒ **No** **Yes** ❒ If "yes" please provide dates: _____

LIST BELOW THE NUMBER OF HOURS WORKED PER YEAR AND Job Description: List below the number of hours worked per year and duties:

Year	Hours worked	Job Description

9. Printed name and title of person verifying employment: _____

10. I hereby certify that I am a custodian of records at _____ and the information submitted on this form is a true and correct representation of this applicant's file with our institution.

11. Signature of employer representative completing this form: _____Date_____

Employer Representative's Signature Must Be Notarized

Sworn to and subscribed before me this

_____ day of _____, 20 _____.

_____

(Notary Public)

My Commission Expires: _____

(Notary Seal)